

<i>SERFF Tracking Number:</i>	<i>UNAM-126734366</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Marquette National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>46293</i>
<i>Company Tracking Number:</i>	<i>MMSA-10-PLAN N AR</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement -</i>	<i>Sub-TOI:</i>	<i>MS08I.001 Plan A 2010</i>
	<i>Standard Plans 2010</i>		
<i>Product Name:</i>	<i>2010 Medicare Supplement</i>		
<i>Project Name/Number:</i>	<i>Plan N/</i>		

## Filing at a Glance

Company: Marquette National Life Insurance Company

Product Name: 2010 Medicare Supplement	SERFF Tr Num: UNAM-126734366	State: Arkansas
TOI: MS08I Individual Medicare Supplement -	SERFF Status: Closed-Approved-	State Tr Num: 46293
Standard Plans 2010	Closed	
Sub-TOI: MS08I.001 Plan A 2010	Co Tr Num: MMSA-10-PLAN N AR	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Stephanie Fowler
	Author: Darlene Lawrence	Disposition Date: 08/26/2010
	Date Submitted: 07/22/2010	Disposition Status: Approved-Closed
		Implementation Date:
Implementation Date Requested: On Approval		
State Filing Description:		

## General Information

Project Name: Plan N	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/26/2010	Explanation for Other Group Market Type:
	State Status Changed: 08/26/2010
Deemer Date:	Created By: Darlene Lawrence
Submitted By: Darlene Lawrence	Corresponding Filing Tracking Number:
Filing Description:	
RE: MARQUETTE NATIONAL LIFE INSURANCE COMPANY	
NAIC Company No.: 71072 FEIN No.: 36-2641398	

FILING TO COMPLY WITH MEDICARE IMPROVEMENTS FOR PATIENTS & PROVIDERS ACT OF 2008 (MIPPA)

MMSI-10-PLAN N AR – Medicare Supplement Policy Plan N

MMSI-S-10-PLAN N AR – Medicare Select Policy Plan N

OC-MMSI-S-AR-10 R (N) - Outline of Coverage

SERFF Tracking Number: UNAM-126734366 State: Arkansas  
 Filing Company: Marquette National Life Insurance Company State Tracking Number: 46293  
 Company Tracking Number: MMSA-10-PLAN N AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
 Standard Plans 2010  
 Product Name: 2010 Medicare Supplement  
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## Actuarial Memorandum and Rates

Dear Sir/Madam:

The above forms are being submitted for your review and approval in order to comply with the amended NAIC Medigap model as required by the federal Medicare Improvements for Patients & Providers Act of 2008 (MIPPA).

Form OC-MMSI-S-AR-10 R (N) will be replacing previously approved form, OC-MMSI-S-AR-10 R, approved on April 22, 2010. The co-payment and deductible figures in the Outline of Coverage, will be changed each year to correspond with changes in Medicare benefit levels. All possible premiums for the prospective applicant have been included in the form of a separate attachment to the Outline.

Forms previously approved to be used with this policy form are listed below with your Department's approval date:

### FORM NUMBER DESCRIPTION APPROVAL DATE

MN-MSUP-APP (1/06) AR Application December 9, 2005

MN-GI (1/06) AR Medicare Supplement Guaranteed Issue Determination Application December 9, 2005

RF-MMS (1/06) Replacement Notice December 9, 2005

MMS-S-DOB

Description of Benefits (Used with Select Policies) December 27, 2005

MNINFO AR Important Information for Residents of Arkansas December 9, 2005

We will continue to use the network previously approved with our other Medicare Select Plans. The network is filed for your review on a quarterly basis.

This coverage will be marketed on a personal contact basis by our licensed agents.

Thank you for your assistance with this filing. If you have any questions, please call me at (800) 882-1054, extension 4104346. My email address is dlawrence@uafe.com. My fax number is (407) 995-8021.

## Company and Contact

### Filing Contact Information

Darlene Lawrence, dlawrence@uafe.com  
 P.O. Box 958465 407-628-1776 [Phone] 8320 [Ext]  
 Lake Mary, FL 32795-8465

### Filing Company Information

Marquette National Life Insurance Company	CoCode: 71072	State of Domicile: Texas
1001 Heathrow Park Lane	Group Code: 953	Company Type:
Suite 5001	Group Name:	State ID Number:
Lake Mary, FL 32746	FEIN Number: 36-2641398	
(407) 995-8000 ext. [Phone]		

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## Filing Fees

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Marquette National Life Insurance Company	\$100.00	07/22/2010	38218087
Marquette National Life Insurance Company	\$50.00	07/26/2010	38285615

SERFF Tracking Number: UNAM-126734366 State: Arkansas

Filing Company: Marquette National Life Insurance Company State Tracking Number: 46293

Company Tracking Number: MMSA-10-PLAN N AR

TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
Standard Plans 2010

Product Name: 2010 Medicare Supplement

Project Name/Number: Plan N/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/26/2010	08/26/2010

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	08/19/2010	08/19/2010	Darlene Lawrence	08/26/2010	08/26/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Filing Fees	Note To Reviewer	Darlene Lawrence	07/26/2010	07/26/2010
Filing Fees	Note To Filer	Stephanie Fowler	07/23/2010	07/23/2010

<i>SERFF Tracking Number:</i>	<i>UNAM-126734366</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Project Name/Number:</i>	<i>Plan N/</i>		

## Disposition

Disposition Date: 08/26/2010

Implementation Date:

Status: Approved-Closed

Comment: This approval is subject to the following:

- Increases will not be given more frequently than once in a twelve-month period;
- Both the insured and agent shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

SERFF Tracking Number: UNAM-126734366 State: Arkansas

Filing Company: Marquette National Life Insurance Company State Tracking Number: 46293

Company Tracking Number: MMSA-10-PLAN N AR

TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
Standard Plans 2010

Product Name: 2010 Medicare Supplement

Project Name/Number: Plan N/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Form (revised)	Medicare Supplement Plan N	Approved	Yes
Form	Medicare Supplement Plan N	Disapproved	Yes
Form	Medicare Select Plan N	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Rate	Rates	Approved	Yes
Rate	Rates	Approved	Yes

SERFF Tracking Number: UNAM-126734366 State: Arkansas  
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TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
Standard Plans 2010  
Product Name: 2010 Medicare Supplement  
Project Name/Number: Plan N/

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 08/19/2010  
Submitted Date 08/19/2010  
Respond By Date 09/20/2010

Dear Darlene Lawrence,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Medicare Supplement Plan N, MMSI-10-PLAN N AR (Form)

Comment: This form states that it is offering benefits for Plan D. Please check the "Additional Benefits" section of this policy.

Please feel free to contact me if you have questions.

Sincerely,  
Stephanie Fowler

SERFF Tracking Number: UNAM-126734366 State: Arkansas  
 Filing Company: Marquette National Life Insurance Company State Tracking Number: 46293  
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 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
 Standard Plans 2010  
 Product Name: 2010 Medicare Supplement  
 Project Name/Number: Plan N/

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 08/26/2010  
 Submitted Date 08/26/2010

Dear Stephanie Fowler,

### Comments:

Thank you for your prompt review.

### Response 1

Comments: The "D" in the Benefits Section of the policy has been corrected to state "N".

### Related Objection 1

Applies To:

- Medicare Supplement Plan N, MMSI-10-PLAN N AR (Form)

Comment:

This form states that it is offering benefits for Plan D. Please check the "Additional Benefits" section of this policy.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Medicare Supplement Plan N	MMSI-10-PLAN N AR		Policy/Contract/Fraternal Certificate	Initial		42.400	Medicare Supplement Plan N.pdf
<b>Previous Version</b>							
Medicare Supplement Plan N	MMSI-10-PLAN N AR		Policy/Contract/Fraternal Certificate	Initial		42.400	Medicare Supplement Plan N



<i>SERFF Tracking Number:</i>	<i>UNAM-126734366</i>	<i>State:</i>	<i>Arkansas</i>
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	<i>Standard Plans 2010</i>		
<i>Product Name:</i>	<i>2010 Medicare Supplement</i>		
<i>Project Name/Number:</i>	<i>Plan N/</i>		

N.pdf

No Rate/Rule Schedule items changed.

Please contact me with any questions.

Sincerely,  
Darlene Lawrence

*SERFF Tracking Number:* UNAM-126734366 *State:* Arkansas  
*Filing Company:* Marquette National Life Insurance Company *State Tracking Number:* 46293  
*Company Tracking Number:* MMSA-10-PLAN N AR  
*TOI:* MS08I Individual Medicare Supplement - *Sub-TOI:* MS08I.001 Plan A 2010  
Standard Plans 2010  
*Product Name:* 2010 Medicare Supplement  
*Project Name/Number:* Plan N/

**Note To Reviewer**

**Created By:**

Darlene Lawrence on 07/26/2010 01:13 PM

**Last Edited By:**

Stephanie Fowler

**Submitted On:**

08/26/2010 01:35 PM

**Subject:**

Additional Filing Fees

**Comments:**

The additional \$50 has been submitted.

*SERFF Tracking Number:* UNAM-126734366 *State:* Arkansas  
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*Company Tracking Number:* MMSA-10-PLAN N AR  
*TOI:* MS08I Individual Medicare Supplement - *Sub-TOI:* MS08I.001 Plan A 2010  
Standard Plans 2010  
*Product Name:* 2010 Medicare Supplement  
*Project Name/Number:* Plan N/

**Note To Filer**

**Created By:**

Stephanie Fowler on 07/23/2010 01:01 PM

**Last Edited By:**

Stephanie Fowler

**Submitted On:**

08/26/2010 01:35 PM

**Subject:**

Filing Fees

**Comments:**

The correct filing fee is \$50 per form. Please submit an additional \$50 for this filing.

SERFF Tracking Number: UNAM-126734366 State: Arkansas

Filing Company: Marquette National Life Insurance Company State Tracking Number: 46293

Company Tracking Number: MMSA-10-PLAN N AR

TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
Standard Plans 2010

Product Name: 2010 Medicare Supplement

Project Name/Number: Plan N/

## Form Schedule

### Lead Form Number: MMSA-10-PLAN N AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 08/26/2010	MMSI-10- PLAN N AR	Policy/Cont ractal/Fratern al Certificate	Medicare Supplement Plan N	Initial		42.400	Medicare Supplement Plan N.pdf
Approved 08/26/2010	MMSI-S- 10-PLAN N AR	Policy/Cont ractal/Fratern al Certificate	Select Plan N	Initial		40.700	Medicare Select Plan N.pdf
Approved 08/26/2010	OC-MMSI- S-AR-10 R (N)	Outline of Coverage	Outline of Coverage	Initial			Outline of Coverage.pdf

# MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas  
Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547  
Phone: (800) 934-8203  
A Stock Company

## MEDICARE SUPPLEMENT POLICY – PLAN N

### IMPORTANT NOTICE

PLEASE READ THE COPY OF YOUR APPLICATION ATTACHED TO THIS POLICY. OMISSIONS OR MATERIAL MISSTATEMENTS IN THE APPLICATION COULD CAUSE AN OTHERWISE VALID CLAIM TO BE DENIED AND YOUR POLICY RESCINDED. REVIEW THE APPLICATION AND WRITE US AT THE ADDRESS SHOWN ABOVE, WITHIN 30 DAYS, IF ANY INFORMATION IS NOT CORRECT OR IF ANY PAST MEDICAL HISTORY HAS BEEN LEFT OUT. NO CHANGE IN THIS POLICY SHALL BE VALID UNTIL APPROVED BY AN EXECUTIVE OFFICER OF THE INSURER AND UNLESS SUCH APPROVAL BE ENDORSED HEREON OR ATTACHED HERETO. NO AGENT HAS THE AUTHORITY TO CHANGE THIS POLICY OR TO WAIVE ANY OF ITS PROVISIONS.

**THIS IS A LEGAL CONTRACT. PLEASE READ IT CAREFULLY.**

**NOTICE TO THE BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

### PART 1

#### RENEWAL PROVISIONS

**This Policy is Guaranteed Renewable For Life. We Reserve The Right to Change Premium Rates.**

You may renew this policy for life by paying the premiums when due. This means that we agree to keep your coverage in force as long as you continue to pay the premiums on a timely basis (see Grace Period provision). While this policy is in force, we agree never to rider, reduce benefits, or change this policy in any way because of a change in your health.

### PREMIUMS

Premiums do not increase each year because of an increase in attained age. On each premium due date, the premium may change if a new rate is applicable to the policy. The increase applies to all covered persons in the same class. You will be notified in writing at least 31 days before any change in the rates.

### PREMIUM RATES SUBJECT TO CHANGE

#### Notice of Your Right to Examine Policy for 30 Days

If, for any reason, you are not satisfied with this policy, you can return it to us for a prompt and full refund. You can mail it to us at our Administrative Office, P.O. Box 13547, Pensacola, Florida 32591-3547, or to the agent through whom it was purchased. It must however, be mailed within 30 days from the date you received it.

This is a non-participating policy. It will not share in any distribution of our profits or surplus earnings. We will not pay any dividends on this policy.

Marquette National Life Insurance Company has caused this policy to be signed by its President and Secretary.

  
Secretary

  
President

### MEDICARE SUPPLEMENT POLICY – PLAN D

#### NON-PARTICIPATING

For Service or Information Call (800) 934-8203

**THIS POLICY CONTAINS A PRE-EXISTING CONDITION LIMITATION**

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**PART 2**

**POLICY SCHEDULE**

**MEDICARE SUPPLEMENT PLAN N**

POLICY: [018042601]

EFFECTIVE DATE: [June 1, 2010]

INSURED'S NAME: [John A. Doe]

AGE: [65]

INITIAL PREMIUM: \$[XXX.XX]

PREMIUM MODE: [Annual]

MODE PREMIUM:	ANNUALLY:	\$[XXX.XX]	SEMI-ANNUALLY:	\$[XXX.XX]
	QUARTERLY:	\$[XXX.XX]	MONTHLY PAC:	\$[XX.XX]
	CREDIT CARD:	\$[XX.XX]		

FIRST RENEWAL DATE: [June 1, 2011]

THE PREMIUM MAY CHANGE ON A CLASS BASIS, AS DESCRIBED ON PAGE 1 OF THIS POLICY.

### **PART 3 INSURING AGREEMENT**

#### **Who Is Covered**

We hereby insure you for losses from injury and sickness. The payment of benefits is subject to all of the provisions, definitions and limitations contained in this policy. This contract is made with you as the signer of the application for this policy. Every transaction relating to this policy is strictly between you and us.

#### **Consideration**

This policy is issued in consideration of your statements and answers made in the application and the advance payment of the first premium. A copy of the application is attached to, and made a part of this policy. Please read the copy of your application attached to this policy. Omissions or material misstatements in the application could cause an otherwise valid claim to be denied. Review the application and write us within 30 days if any information is not correct or if any past medical history has been left out.

#### **When Coverage Is Effective**

This policy shall take effect at 12:00 a.m., midnight, Standard Time, at the place where you live. The initial term ends at the same hour of the last day of the grace period, on which the initial term expires. The effective date of this policy, the initial premium and first renewal date are all shown in the Policy Schedule.

### **PART 4 PLAN OF BENEFITS - PLAN N**

**Co-payments apply to physician office visits, including visits to medical specialists, and to emergency room visits. The emergency room co-payment will be waived if you are admitted to the hospital, and the visit is subsequently covered as a Medicare Part A expense.**

#### **What We Will Pay**

##### **CORE BENEFITS**

When you are confined in a Hospital as a Resident Patient and Medicare pays for the confinement, we will pay Medicare Eligible Expenses as follows during each benefit period. Such confinement must be due to injury or sickness.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61<sup>st</sup> day through the 90<sup>th</sup> day in any Medicare benefit period.
2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.



## **ADDITIONAL BENEFITS**

1. Medicare Part A Deductible: Coverage for the Medicare Part A inpatient hospital deductible amount per benefit period.
2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.
3. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

## **PART 5 ELIGIBILITY**

### **Who Can Be Insured**

Only you are eligible to be covered. In addition, you must be: (1) age 65; and (2) covered by Medicare Parts A and B.

## **PART 6 TERMINATION OF COVERAGE**

### **Lifetime Coverage If Premiums Are Paid**

The insurance coverage shall continue for life, provided all premiums are paid.

If any premium payment is not received by us or paid to an agent authorized by us, on or before any premium due date, or within the grace period as provided, this policy shall terminate without further notice. However, such termination is without prejudice to any claim for loss incurred prior to that time.

## **PART 7 PRE-EXISTING CONDITION LIMITATIONS**

### **Pre-Existing Conditions Are Not Covered For 6 Months**

Pre-existing Conditions are covered after this policy has been in force for 6 months. See definition of Pre-existing Condition in Part 10.

If, as of the date of application, you had a Continuous Period of Creditable Coverage or had prior coverage under a Medicare Supplement policy for at least 6 months, we will not exclude benefits based on a pre-existing condition. If, as of the date of application, you had a Continuous Period of Creditable Coverage or had prior coverage under a Medicare Supplement policy for less than 6 months, we will reduce the period of the pre-existing condition limitation by the time covered under such prior coverage.

We will waive any pre-existing condition limitation if you applied for and were issued this policy under a qualified guaranteed issue status.

## **PART 8 CHANGES IN MEDICARE**

### **Automatic Benefit Adjustment**

If changes are made in Medicare deductibles, coinsurance payments or other Medicare benefits, coverage provided by this policy will be automatically adjusted to coincide with these changes. The policy benefits will not duplicate benefits paid by Medicare. Premiums may be modified as necessary to correspond with these changes.

**PART 9**  
**SUSPENSION OF COVERAGE BY POLICYHOLDER**

**Entitlement To Title XIX of the Social Security Act "Medicaid"**  
**Or Coverage Under Group Health Plan Under Section 226(b) of the Social Security Act**

If, within ninety (90) days after the date you become entitled to medical assistance under Title XIX of the Social Security Act (Medicaid), you notify us, the benefits and premium under this policy shall be suspended for the period in which you applied for and were determined to be entitled to Medicaid. The suspension period shall not exceed 24 months.

If you become entitled to benefits under section 226 (b) of the Social Security Act (42 USC section 426) and are covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act), at your request the benefits and premiums under this policy will be suspended for any period provided by federal regulation.

If such suspension occurs and you lose entitlement to Medicaid or coverage under a group health plan, this policy will be automatically reinstituted effective as of the date of termination of entitlement to Medicaid or loss of group coverage, if you provide notice of loss of such entitlement to us within ninety (90) days after the date of such loss and pay the premium attributable to the period.

If the coverage of this policy is reinstituted: (1) there will be no waiting period for treatment of pre-existing conditions; (2) the coverage will be substantially equivalent to the coverage in effect before the date of such suspension; and (3) premiums on terms at least as favorable to you as the premium terms you would have had if your coverage had not been suspended.

**PART 10**  
**DEFINITIONS**

**Some Important Definitions Of Words And Phrases**

- A. "Benefit Period" means a period which begins, after the Effective Date of this policy, with the first day you are entitled to benefits under this policy for confinement in a hospital. It ends with the first period of 60 consecutive days thereafter, during which you are not confined in a hospital or skilled nursing care facility.
- B. "Continuous Period of Creditable Coverage" means the period during which you were covered by Creditable Coverage, if during the period of the coverage you had no breaks in coverage greater than 63 days.
- C. "Creditable Coverage" means coverage under any of the following: a) A group health plan; b) Health insurance coverage; c) Part A or Part B of Title XVIII of the Social Security Act (Medicare); d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; e) Chapter 55 of Title 10 (CHAMPUS), f) A medical care program of the Indian Health Service or of a tribal organization; g) A state health benefits risk pool; h) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health benefit program); i) A public health plan (as defined in Federal regulation); or j) A health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).
- D. "Emergency Care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.
- E. "Home" means any place used by you as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing care facility shall not be considered your place of residence.
- F. "Hospice Care" means treatment in a hospice program as defined by Medicare.
- G. "Hospital" means a hospital that is approved or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.
- H. "Injury or Injuries" for which benefits are provided means accidental bodily injury sustained by you which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this policy is in force.

- I. "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.
- J. "Medicare Eligible Expenses" are those expenses of the kind covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
- K. "Physician" means a duly licensed practitioner of the healing arts who is practicing within the scope of his or her license.
- L. "Pre-Existing Condition" means a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
- M. "Resident Patient" means a person confined in a hospital for treatment of injury or sickness. This shall not include a person receiving any form of rest, nursing, convalescent, or custodial care.
- N. "Respite Care" is treatment that meets Medicare's definition of respite care.
- O. "Sickness" means illness or disease incurred by you which was diagnosed or treated after the effective date of this policy and while this policy is in force.
- P. "Skilled Nursing Care Facility" means a facility that is operated pursuant to law; approved for payment of Medicare benefits or be qualified to receive such approval if so requested; be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; provides continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and maintains a daily medical record of each patient. This does not include any home, facility, or part thereof used primarily for rest; a home or facility for the aged or for the care or treatment of drug and alcohol abuse; or a home or facility primarily used for the care and treatment of mental disease or disorders or custodial or educational care.
- Q. "We" or "Us" means our Company named on the first page of the policy.
- R. "You" or "Your" means the person insured by this policy shown as the applicant on the attached application.

## **PART 11 EXCLUSIONS**

### **What We Will Not Pay For**

This policy does not pay for expenses of the kind not covered by Medicare.

## **PART 12 UNIFORM PROVISIONS**

### **Entire Contract; Changes**

This policy with the application and attached papers is the entire contract of insurance between you and our Company. No change in this policy will be valid until approved by an executive officer of the Company. This approval must be noted on or attached to this policy. No agent has the authority to change this policy or waive any of its provisions.

### **Change of Beneficiary**

You can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

### **Time Limit On Certain Defenses**

After two years from the issue date, only fraudulent misstatements made by the applicant in the application may be used to: (1) void the policy; or (2) deny any claim for loss incurred after the 2-year period.

No claim for loss incurred commencing after 6 months from the date of issue of this policy shall be reduced or denied on the grounds that a disease or physical condition effective on the date of loss had existed prior to the effective date of coverage of this policy.

**Grace Period**

This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period the policy will stay in force.

**Reinstatement**

If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by us (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If we require an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt, unless we have previously written to you giving our disapproval. The reinstated policy will cover only losses that result from an injury or sickness that occurs after the date of reinstatement. In all other respects, your rights, and ours, will remain the same, subject to any provisions noted on, or attached to the reinstated policy.

**Notice of Claim**

Written notice of claim must be given within 20 days after a covered loss starts, or as soon as reasonably possible. The notice can be given to us at our Administrative Office, or to our agent. Notice should include your name and the policy number.

**Claim Forms**

When we receive a notice of claim, we will send you forms for filing proof of loss. If these forms are not given to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

**Time of Payment of Claims**

Benefits for any loss covered by this policy will be paid as soon as we receive proper written proof.

**Proof of Loss**

Written proof of loss must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce nor deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified, unless you were legally incapacitated.

**Payment of Claims**

Benefits will be paid to you. Loss of life benefits are payable in accordance with the beneficiary designation at the time of payment. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at our option, either to your beneficiary or estate. The proceeds payable to the insured or his estate shall include premiums paid for any period beyond the end of the policy month in which death occurred and shall be paid in a lump sum no later than 30 days after we receive proof of the insured's death.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000 to someone related to you or your beneficiary by blood or marriage, whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

**Extension of Benefits**

Termination of a Medicare Supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**Physical Examinations and Autopsy**

We, at our own expense, shall have the right and opportunity to examine the insured when and as often as we may reasonably require while a claim is pending. We shall also have the right to have an autopsy made, at our own expense, unless prohibited by law.

**Legal Action**

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by the policy. No such action may be brought after the expiration of three years from the time written proof of loss is required to be given.

**Misstatement of Age**

If your age has been misstated, benefits will be based on what the premium paid would have purchased at the correct age.

**Unpaid Premium**

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**Conformity With State Statutes**

Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you live on that date, is amended to conform to the minimum requirements of such laws.

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## **MARQUETTE NATIONAL LIFE INSURANCE COMPANY**

Home Office: Houston, Texas

Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547

Phone: (800) 934-8203

# MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas  
Administrative Office: P.O. Box 13547, Pensacola, Florida 32591-3547  
Phone: (800) 934-8203  
A Stock Company

## MEDICARE SUPPLEMENT SELECT POLICY – PLAN N

### IMPORTANT NOTICE

PLEASE READ THE COPY OF YOUR APPLICATION ATTACHED TO THIS POLICY. OMISSIONS OR MATERIAL MISSTATEMENTS IN THE APPLICATION COULD CAUSE AN OTHERWISE VALID CLAIM TO BE DENIED AND YOUR POLICY RESCINDED. REVIEW THE APPLICATION AND WRITE US AT THE ADDRESS SHOWN ABOVE, WITHIN 30 DAYS, IF ANY INFORMATION IS NOT CORRECT OR IF ANY PAST MEDICAL HISTORY HAS BEEN LEFT OUT. NO CHANGE IN THIS POLICY SHALL BE VALID UNTIL APPROVED BY AN EXECUTIVE OFFICER OF THE INSURER AND UNLESS SUCH APPROVAL BE ENDORSED HEREON OR ATTACHED HERETO. NO AGENT HAS THE AUTHORITY TO CHANGE THIS POLICY OR TO WAIVE ANY OF ITS PROVISIONS.

**THIS IS A LEGAL CONTRACT. PLEASE READ IT CAREFULLY.**

**NOTICE TO THE BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

### PART 1

#### THIS POLICY IS A MEDICARE SELECT POLICY

To receive full benefits under this policy, you are required to use hospitals which are participants in the Marquette National Life Insurance Company's Medicare Select Program. Please read the Benefit Provisions carefully.

### PART 2

#### RENEWAL PROVISIONS

**This Policy is Guaranteed Renewable For Life. We Reserve The Right to Change Premium Rates.**

You may renew this policy for life by paying the premiums when due. This means that we agree to keep your coverage in force as long as you continue to pay the premiums on a timely basis (see Grace Period provision). While this policy is in force, we agree never to rider, reduce benefits, or change this policy in any way because of a change in your health.

### PREMIUMS

Premiums do not increase each year because of an increase in attained age. On each premium due date, the premium may change if a new rate is applicable to the policy. The increase applies to all covered persons in the same class. You will be notified in writing at least 31 days before any change in the rates.

### PREMIUM RATES SUBJECT TO CHANGE

#### Notice of Your Right to Examine Policy for 30 Days

If, for any reason, you are not satisfied with this policy, you can return it to us for a prompt and full refund. You can mail it to us at our Administrative Office, P.O. Box 13547, Pensacola, Florida 32591-3547, or to the agent through whom it was purchased. It must however, be mailed within 30 days from the date you received it.

This is a non-participating policy. It will not share in any distribution of our profits or surplus earnings. We will not pay any dividends on this policy.

Marquette National Life Insurance Company has caused this policy to be signed by its President and Secretary.

  
Secretary

  
President

## MEDICARE SUPPLEMENT SELECT POLICY – PLAN N

### NON-PARTICIPATING

For Service or Information Call (800) 934-8203

**THIS POLICY CONTAINS A PRE-EXISTING CONDITION LIMITATION**



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**PART 3**

**POLICY SCHEDULE**

**MEDICARE SUPPLEMENT SELECT PLAN N**

POLICY: [018042601]

EFFECTIVE DATE: [June 1, 2010]

INSURED'S NAME: [John A. Doe]

AGE: [65]

INITIAL PREMIUM: \$[XXX.XX]

PREMIUM MODE: [Annual]

MODE PREMIUM:	ANNUALLY:	\$[XXX.XX]	SEMI-ANNUALLY:	\$[XXX.XX]
	QUARTERLY:	\$[XXX.XX]	MONTHLY PAC:	\$[XX.XX]
	CREDIT CARD:	\$[XX.XX]		

FIRST RENEWAL DATE: [June 1, 2011]

THE PREMIUM MAY CHANGE ON A CLASS BASIS, AS DESCRIBED ON PAGE 1 OF THIS POLICY.

## **PART 4 INSURING AGREEMENT**

### **Who Is Covered**

We hereby insure you for losses from injury and sickness. The payment of benefits is subject to all of the provisions, definitions and limitations contained in this policy. This contract is made with you as the signer of the application for this policy. Every transaction relating to this policy is strictly between you and us.

### **Consideration**

This policy is issued in consideration of your statements and answers made in the application and the advance payment of the first premium. A copy of the application is attached to, and made a part of this policy. Please read the copy of your application attached to this policy. Omissions or material misstatements in the application could cause an otherwise valid claim to be denied. Review the application and write us within 30 days if any information is not correct or if any past medical history has been left out.

### **When Coverage Is Effective**

This policy shall take effect at 12:00 a.m., midnight, Standard Time, at the place where you live. The initial term ends at the same hour of the last day of the grace period, on which the initial term expires. The effective date of this policy, the initial premium and first renewal date are all shown in the Policy Schedule.

## **PART 5 PLAN OF BENEFITS – SELECT PLAN N**

**Co-payments apply to physician office visits, including visits to medical specialists, and to emergency room visits. The emergency room co-payment will be waived if you are admitted to the hospital, and the visit is subsequently covered as a Medicare Part A expense.**

### **What We Will Pay**

#### **CORE BENEFITS**

When you are confined in a Hospital as a Resident Patient and Medicare pays for the confinement, we will pay Medicare Eligible Expenses as follows during each benefit period. Such confinement must be due to injury or sickness.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61<sup>st</sup> day through the 90<sup>th</sup> day in any Medicare benefit period.
2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

## **ADDITIONAL BENEFITS**

1. **Medicare Part A Deductible:** Coverage for the Medicare Part A inpatient hospital deductible amount per benefit period. (You must use a Participating Hospital or meet the requirements of Part 6 in order to receive this benefit.)
2. **Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.
3. **Medically Necessary Emergency Care in a Foreign Country:** Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

### **PART 6 BENEFITS FOR NON-PARTICIPATING HOSPITALS**

We will waive the initial Medicare Part A deductible amount when you are admitted to a non-participating hospital:

1. for emergency care and it is not reasonably possible to obtain such services through a participating hospital;
2. outside the service area and you require urgently needed services;
3. for non-emergency care and the services you require are not available at a participating hospital. We reserve the right to determine and verify the non-availability of such services.

For all other services received in a non-participating hospital, it will be your responsibility to pay the Medicare Part A deductible.

### **PART 7 CONTINUATION**

In the event regulators determine that Medicare Supplement Select policies issued should be discontinued due to either the failure of the Medicare Select Program to be re-authorized or its substantial amendment, we will continue your coverage for a period of one year from the date we are notified of such discontinuance. Following the one-year period, your Medicare Supplement Select policy is converted to a Medicare Supplement policy offered by us which has comparable or lesser benefits and which does not contain a restricted network provision.

### **PART 8 CONVERSION**

If you decide not to participate in our Participating Hospital Network, you may convert your Medicare Supplement Select policy to any Medicare Supplement policy offered by us which has comparable or lesser benefits and which does not contain a restricted network provision. You will not have to provide evidence of insurability if your current policy has been in force for more than 90 days.

### **PART 9 ELIGIBILITY**

#### **Who Can Be Insured**

Only you are eligible to be covered. In addition, you must be: (1) age 65; and (2) covered by Medicare Parts A and B.

## **PART 10 TERMINATION OF COVERAGE**

### **Lifetime Coverage If Premiums Are Paid**

The insurance coverage shall continue for life, provided all premiums are paid.

If any premium payment is not received by us or paid to an agent authorized by us, on or before any premium due date, or within the grace period as provided, this policy shall terminate without further notice. However, such termination is without prejudice to any claim for loss incurred prior to that time.

## **PART 11 PRE-EXISTING CONDITION LIMITATIONS**

### **Pre-Existing Conditions Are Not Covered For 6 Months**

Pre-existing Conditions are covered after this policy has been in force for 6 months. See definition of Pre-existing Condition in Part 14.

If, as of the date of application, you had a Continuous Period of Creditable Coverage or had prior coverage under a Medicare Supplement policy for at least 6 months, we will not exclude benefits based on a pre-existing condition. If, as of the date of application, you had a Continuous Period of Creditable Coverage or had prior coverage under a Medicare Supplement policy for less than 6 months, we will reduce the period of the pre-existing condition limitation by the time covered under such prior coverage.

We will waive any pre-existing condition limitation if you applied for and were issued this policy under a qualified guaranteed issue status.

## **PART 12 CHANGES IN MEDICARE**

### **Automatic Benefit Adjustment**

If changes are made in Medicare deductibles, coinsurance payments or other Medicare benefits, coverage provided by this policy will be automatically adjusted to coincide with these changes. The policy benefits will not duplicate benefits paid by Medicare. Premiums may be modified as necessary to correspond with these changes.

## **PART 13 SUSPENSION OF COVERAGE BY POLICYHOLDER**

### **Entitlement To Title XIX of the Social Security Act "Medicaid" Or Coverage Under Group Health Plan Under Section 226(b) of the Social Security Act**

If, within ninety (90) days after the date you become entitled to medical assistance under Title XIX of the Social Security Act (Medicaid), you notify us, the benefits and premium under this policy shall be suspended for the period in which you applied for and were determined to be entitled to Medicaid. The suspension period shall not exceed 24 months.

If you become entitled to benefits under section 226 (b) of the Social Security Act (42 USC section 426) and are covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act), at your request the benefits and premiums under this policy will be suspended for any period provided by federal regulation.

If such suspension occurs and you lose entitlement to Medicaid or coverage under a group health plan, this policy will be automatically reinstituted effective as of the date of termination of entitlement to Medicaid or loss of group coverage, if you provide notice of loss of such entitlement to us within ninety (90) days after the date of such loss and pay the premium attributable to the period.

If the coverage of this policy is reinstituted: (1) there will be no waiting period for treatment of pre-existing conditions; (2) the coverage will be substantially equivalent to the coverage in effect before the date of such suspension; and (3) premiums on terms at least as favorable to you as the premium terms you would have had if your coverage had not been suspended.

## **PART 14 DEFINITIONS**

### **Some Important Definitions Of Words And Phrases**

- A. "Benefit Period" means a period which begins, after the Effective Date of this policy, with the first day you are entitled to benefits under this policy for confinement in a hospital. It ends with the first period of 60 consecutive days thereafter, during which you are not confined in a hospital or skilled nursing care facility.
- B. "Care Provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse, provided through a licensed home health care agency, or referred by a licensed referral agency or licensed nurses registry.
- C. "Continuous Period of Creditable Coverage" means the period during which you were covered by Creditable Coverage, if during the period of the coverage you had no breaks in coverage greater than 63 days.
- D. "Creditable Coverage" means coverage under any of the following: a) A group health plan; b) Health insurance coverage; c) Part A or Part B of Title XVIII of the Social Security Act (Medicare); d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; e) Chapter 55 of Title 10 (CHAMPUS), f) A medical care program of the Indian Health Service or of a tribal organization; g) A state health benefits risk pool; h) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health benefit program); i) A public health plan (as defined in Federal regulation); or j) A health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).
- E. "Emergency Care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.
- F. "Home" means any place used by you as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing care facility shall not be considered your place of residence.
- G. "Hospice Care" means treatment in a hospice program as defined by Medicare.
- H. "Hospital" means a hospital that is approved or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.
- I. "Injury or Injuries" for which benefits are provided means accidental bodily injury sustained by you which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this policy is in force.
- J. "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.
- K. "Medicare Eligible Expenses" are those expenses of the kind covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
- L. "Non-participating Hospital" means a hospital that does not have an agreement with us or has not been designated by us to provide hospital services.
- M. "Participating Hospital" means a hospital that has an agreement with us and/or has been designated by us to provide hospital services.
- N. "Physician" means a duly licensed practitioner of the healing arts who is practicing within the scope of his or her license.
- O. "Pre-Existing Condition" means a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
- P. "Resident Patient" means a person confined in a hospital for treatment of injury or sickness. This shall not include a person receiving any form of rest, nursing, convalescent, or custodial care.
- Q. "Respite Care" is treatment that meets Medicare's definition of respite care.

- R. "Service Area" means the geographical area as approved by the Commissioner of Insurance within which we provide or arrange for health care services that are available and accessible.
- S. "Sickness" means illness or disease incurred by you which was diagnosed or treated after the effective date of this policy and while this policy is in force.
- T. "Skilled Nursing Care Facility" means a facility that is operated pursuant to law; approved for payment of Medicare benefits or be qualified to receive such approval if so requested; be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; provides continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and maintains a daily medical record of each patient. This does not include any home, facility, or part thereof used primarily for rest; a home or facility for the aged or for the care or treatment of drug and alcohol abuse; or a home or facility primarily used for the care and treatment of mental disease or disorders or custodial or educational care.
- U. "Temporarily Absent" means any circumstances where you have left the service area but intend to return within a reasonable period of time.
- V. "Urgently Needed Services" means covered services which are required in order to prevent serious deterioration in health while you are temporarily absent from the service area.
- W. "We" or "Us" means our Company named on the first page of the policy.
- X. "You" or "Your" means the person insured by this policy shown as the applicant on the attached application.

## **PART 15 EXCLUSIONS**

### **What We Will Not Pay For**

This policy does not pay for expenses of the kind not covered by Medicare.

## **PART 16 UNIFORM PROVISIONS**

### **Entire Contract; Changes**

This policy with the application and attached papers is the entire contract of insurance between you and our Company. No change in this policy will be valid until approved by an executive officer of the Company. This approval must be noted on or attached to this policy. No agent has the authority to change this policy or waive any of its provisions.

### **Change of Beneficiary**

You can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

### **Time Limit On Certain Defenses**

After two years from the issue date, only fraudulent misstatements made by the applicant in the application may be used to: (1) void the policy; or (2) deny any claim for loss incurred after the 2-year period.

No claim for loss incurred commencing after 6 months from the date of issue of this policy shall be reduced or denied on the grounds that a disease or physical condition effective on the date of loss had existed prior to the effective date of coverage of this policy.

### **Grace Period**

This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period the policy will stay in force.

**Reinstatement**

If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by us (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If we require an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt, unless we have previously written to you giving our disapproval. The reinstated policy will cover only losses that result from an injury or sickness that occurs after the date of reinstatement. In all other respects, your rights, and ours, will remain the same, subject to any provisions noted on, or attached to the reinstated policy.

**Notice of Claim**

Written notice of claim must be given within 20 days after a covered loss starts, or as soon as reasonably possible. The notice can be given to us at our Administrative Office, or to our agent. Notice should include your name and the policy number.

**Claim Forms**

When we receive a notice of claim, we will send you forms for filing proof of loss. If these forms are not given to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

**Time of Payment of Claims**

Benefits for any loss covered by this policy will be paid as soon as we receive proper written proof.

**Proof of Loss**

Written proof of loss must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce nor deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified, unless you were legally incapacitated.

**Payment of Claims**

Benefits will be paid to you. Loss of life benefits are payable in accordance with the beneficiary designation at the time of payment. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at our option, either to your beneficiary or estate. The proceeds payable to the insured or his estate shall include premiums paid for any period beyond the end of the policy month in which death occurred and shall be paid in a lump sum no later than 30 days after we receive proof of the insured's death.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000 to someone related to you or your beneficiary by blood or marriage, whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

**Extension of Benefits**

Termination of a Medicare Supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**Physical Examinations and Autopsy**

We, at our own expense, shall have the right and opportunity to examine the insured when and as often as we may reasonably require while a claim is pending. We shall also have the right to have an autopsy made, at our own expense, unless prohibited by law.



**Legal Action**

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by the policy. No such action may be brought after the expiration of three years from the time written proof of loss is required to be given.

**Misstatement of Age**

If your age has been misstated, benefits will be based on what the premium paid would have purchased at the correct age.

**Unpaid Premium**

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**Conformity With State Statutes**

Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you live on that date, is amended to conform to the minimum requirements of such laws.

## **PART 17 GRIEVANCE PROCEDURE**

We have a customer service program which can provide information to you, handle your complaints and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or that you desire to have settled by means of a written grievance.

If while staying at a Network Hospital, you have a complaint regarding hospital services being provided, you may contact the Claims Department by phone (1-800-934-8203) to express the complaint. The Claims Department will relay the complaint to the Network Hospital's Administration on an immediate basis for prompt resolution.

The following procedures are aimed at achieving mutual agreement for the settlement of a dispute:

1. All grievances must be presented to us in written form. Any written grievance between you and us or between you and a hospital must be dealt with through this grievance procedure.
2. Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.
3. A grievance must be filed by submitting the complete details in writing to Marquette National Life Insurance Company, c/o Grievance Appeal Manager, 411 N. Baylen Street, Pensacola, Florida 32501.
4. Each grievance is processed within a maximum of 60 days after it is received by us. Each level of the grievance process is handled by a person with problem-solving authority. A physician, other than your primary care physician, must be involved in reviewing any medically related grievances.
5. If a grievance is found to be valid, corrective action will be taken promptly.
6. All concerned parties are to be notified about the result of a grievance.
7. You have the right to appeal to the Department of Insurance after first completing our grievance process.
8. If, after completing all the steps in the grievance procedure the problem is not satisfactorily resolved, you may request arbitration. Arbitration must be conducted in accordance with the provisions of the applicable state statute.
9. Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.
10. The time for filing a grievance is limited to a period of not more than one year from the date of occurrence.

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## **MARQUETTE NATIONAL LIFE INSURANCE COMPANY**

Home Office: Houston, Texas

Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547

Phone: (800) 934-8203

# Marquette National Life Insurance Company

## Senior Health Service Center

P.O. Box 130 • Pensacola, Florida 32591-0130

### 2010 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE 1 OF 2

#### BENEFIT PLANS A, B, C, D, F, G AND N

Medicare supplement insurance can be sold in only ten standard plans plus a high deductible plan. This chart shows the benefits included in each plan. Every company must make available Plan “A”. Some plans may not be available in your state. Plans E, H, I and J are no longer available for sale.

**BASIC BENEFITS** included in all Plans: **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end; **Medical Expenses** — Part B coinsurance (generally 20% of Medicare-approved expenses); or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments; **Blood** — First three pints of blood each year; and **Hospice** — Part A coinsurance.

B E N E F I T S	PLANS						
	★ A	B	C	★ D*	★ F*	F**	★ G*
	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance
			Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
			Part B Deductible		Part B Deductible	Part B Deductible	
					Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
			Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

★Marks the plans being offered by Marquette National Life Insurance Company.

\*Plans D, F, G and N are also offered as Medicare Supplement Select plans. If you choose a Medicare Select plan, when medical care is provided in a network hospital, the initial Part A Deductible is waived. If medical care is provided in a non-network provider hospital, you are responsible for payment of the initial Part A Deductible.

\*\*Plan “F” also has an option called a high deductible plan pays the same or offer the same benefits as Plan “F” after one has paid a calendar year \$2,000 deductible. Benefits from high deductible Plan “F” will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

# Marquette National Life Insurance Company

Senior Health Service Center

P.O. Box 130 • Pensacola, Florida 32591-0130

## 2010 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE 2

PLANS				
B E N E F I T S	K**	L**	M	★ N*
	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic INCLUDING 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
			Foreign Travel Emergency	Foreign Travel Emergency
	Out-of-pocket limit \$[4,620] paid at 100% after limit reached***	Out-of-pocket limit \$[2,310] paid at 100% after limit reached***		

\*\* The out-of-pocket annual limit does NOT include charges from your provider that exceed medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

\*\*\*The out-of-pocket annual limit will increase each year for inflation.

# Marquette National Life Insurance Company

Use these rates:	If you live in these zip codes:
Area 1	716, 717, 719, 723-729
Area 2	718, 720, 721
Area 3	722

## MEDICARE SUPPLEMENT

## ARKANSAS

### MALE & FEMALE

AREA 1											
Premium Mode	Age	PLAN A		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,390	\$ 1,598	\$ 1,713	\$ 1,970	\$ 1,949	\$ 2,242	\$ 1,812	\$ 2,084	\$ 1,423	\$ 1,636
Semi-Annual	65 and above	723	831	891	1,024	1,014	1,166	942	1,083	740	851
Quarterly	65 and above	368	424	454	522	517	594	480	552	377	434
Monthly CC	65 and above	118	136	146	167	166	191	154	177	121	139
Monthly PAC	65 and above	116	133	143	164	162	187	151	174	119	136

AREA 2											
Premium Mode	Age	PLAN A		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,467	\$ 1,687	\$ 1,808	\$ 2,080	\$ 2,058	\$ 2,366	\$ 1,912	\$ 2,199	\$ 1,502	\$ 1,727
Semi-Annual	65 and above	763	877	940	1,081	1,070	1,231	994	1,144	781	898
Quarterly	65 and above	389	447	479	551	545	627	507	583	398	458
Monthly CC	65 and above	125	143	154	177	175	201	163	187	128	147
Monthly PAC	65 and above	122	141	151	173	171	197	159	183	125	144

AREA 3											
Premium Mode	Age	PLAN A		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,544	\$ 1,776	\$ 1,903	\$ 2,189	\$ 2,166	\$ 2,491	\$ 2,013	\$ 2,315	\$ 1,581	\$ 1,818
Semi-Annual	65 and above	803	924	990	1,138	1,126	1,295	1,047	1,204	822	945
Quarterly	65 and above	409	471	504	580	574	660	533	613	419	482
Monthly CC	65 and above	131	151	162	186	184	212	171	197	134	155
Monthly PAC	65 and above	129	148	159	182	180	208	168	193	132	151

Rate is determined by Underwriting Class and Zip Code. Open Enrollees and Guaranteed Issues use Preferred rate.

# Marquette National Life Insurance Company

Use these rates:	If you live in these zip codes:
Area 1	716, 717, 719, 723-729
Area 2	718, 720, 721
Area 3	722

**MEDICARE  
SELECT**

**ARKANSAS**

## MALE & FEMALE

### AREA 1

Premium Mode	Age	PLAN A (non-SELECT)		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,390	\$ 1,598	\$ 1,540	\$ 1,771	\$ 1,769	\$ 2,035	\$ 1,632	\$ 1,877	\$ 1,296	\$ 1,490
Semi-Annual	65 and above	723	831	801	921	920	1,058	848	976	674	775
Quarterly	65 and above	368	424	408	469	469	539	432	497	343	395
Monthly CC	65 and above	118	136	131	151	150	173	139	160	110	127
Monthly PAC	65 and above	116	133	128	148	147	170	136	156	108	124

### AREA 2

Premium Mode	Age	PLAN A (non-SELECT)		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,467	\$ 1,687	\$ 1,625	\$ 1,870	\$ 1,868	\$ 2,148	\$ 1,722	\$ 1,981	\$ 1,368	\$ 1,573
Semi-Annual	65 and above	763	877	845	972	971	1,117	896	1,030	711	818
Quarterly	65 and above	389	447	431	495	495	569	456	525	363	417
Monthly CC	65 and above	125	143	138	159	159	183	146	168	116	134
Monthly PAC	65 and above	122	141	135	156	156	179	144	165	114	131

### AREA 3

Premium Mode	Age	PLAN A (non-SELECT)		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,544	\$ 1,776	\$ 1,711	\$ 1,968	\$ 1,966	\$ 2,261	\$ 1,813	\$ 2,085	\$ 1,440	\$ 1,656
Semi-Annual	65 and above	803	924	890	1,023	1,022	1,176	943	1,084	749	861
Quarterly	65 and above	409	471	453	522	521	599	480	553	382	439
Monthly CC	65 and above	131	151	145	167	167	192	154	177	122	141
Monthly PAC	65 and above	129	148	143	164	164	188	151	174	120	138

Rate is determined by Underwriting Class and Zip Code. Open Enrollees and Guaranteed Issues use Preferred rate.

### **PREMIUM INFORMATION**

We, Marquette National Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. The premium you pay at each premium due date will be based on the state in which your policy was purchased. The premium amount does not increase each year because of an increase in attained age.

The Premium for this Policy is: Plan \_\_\_\_\_

Annually \$ \_\_\_\_\_; Semi-Annually \$ \_\_\_\_\_;

Quarterly \$ \_\_\_\_\_; Monthly PAC \$ \_\_\_\_\_; Credit Card \$ \_\_\_\_\_

### **DISCLOSURES**

Use this Outline to compare benefits and premiums among policies. This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.

### **READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to our Administrative Office, P.O. Box 13547, Pensacola, Florida 32591-3547. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

### **POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

### **NOTICE**

This policy may not fully cover all of your medical costs. Neither Marquette National nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "*Medicare and You*" for more details.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.



## **GRIEVANCE PROCEDURE\***

We have a customer service program which can provide information to you, handle your complaints and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program, or that you desire to have settled by means of a written grievance.

If while staying at a Network Hospital, you have a complaint regarding hospital services being provided, you may contact the Claims Department by phone (800-934-8203) to express the complaint. The Claims Department will relay the complaint to the Network Hospital's Administration on an immediate basis for prompt resolution.

The following procedures are aimed at achieving mutual agreement for the settlement of a dispute.

1. All grievances must be presented to us in written form. Any written grievance between you and us, or between you and a hospital, must be dealt with through this grievance procedure.
2. Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.
3. A grievance must be filed by submitting the complete details in writing to Marquette National Life Insurance Company, c/o Grievance Appeal Manager, 411 N. Baylen Street, Pensacola, FL 32502.
4. Each grievance is processed within a maximum of 60 days after it is received by us. Each level of the grievance process is handled by a person with problem-solving authority. A physician, other than your primary care physician, must be involved in reviewing any medically related grievances.
5. If a grievance is found to be valid, corrective action will be taken promptly.
6. All concerned parties are to be notified about the result of a grievance.
7. You have the right to appeal to the Department of Insurance after first completing our grievance process.
8. If, after completing all the steps in the grievance procedure the problem is not satisfactorily resolved, you may request arbitration. Arbitration must be conducted in accordance with the provisions of the applicable state statute.
9. Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.
10. The time for filing a grievance is limited to a period of not more than one year from the date of occurrence.

\*Grievance Procedure only applies to Medicare Select Plans.

# Plan A

## Medicare (Part A) - Hospital Services - Per Benefit Period

\*A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days  Beyond the Additional 365 Days	   All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	   \$0  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	   \$1,100 (Part A Deductible)  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	   All approved amounts  All but \$137.50 a day  \$0	   \$0  \$0  \$0	   \$0  Up to \$137.50 a day  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	 \$0  100%	 3 pints  \$0	 \$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan A

## Medicare (Part B) - Medical Services - Per Calendar Year

\*Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$155 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B Deductible) \$0

# Plan B

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*\* If you do not utilize a network provider for Medicare Select plans, you are responsible for the Part A Deductible.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st through 90th day 91st day and after: While using 60 Lifetime Reserve Days Once Lifetime Reserve Days are used: Additional 365 Days Beyond the Additional 365 Days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A Deductible)*** \$275 a day \$550 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan B

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$155 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B Deductible) \$0

# Plan C

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days  Beyond the Additional 365 Days	   All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	   \$1,100 (Part A Deductible)  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	   \$0  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	   All approved amounts  All but \$137.50 a day  \$0	   \$0  Up to \$137.50 a day  \$0	   \$0  \$0  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	 \$0  100%	 3 pints  \$0	 \$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan C

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$155 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%   \$0 80%	\$0   \$155 (Part B Deductible) 20%	\$0   \$0 \$0

(continued)

# Plan C

## OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>FOREIGN TRAVEL- NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside of the U.S.A. First \$250 each calendar year Remainder of Charges	   \$0  \$0	   \$0  80% to a lifetime maximum benefit of \$50,000	   \$250  20% and amounts over the \$50,000 lifetime maximum



# Plan D

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days  Beyond the Additional 365 Days	          All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	          \$1,100 (Part A Deductible)  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	          \$0  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	          All approved amounts  All but \$137.50 a day  \$0	          \$0  Up to \$137.50 a day  \$0	          \$0  \$0  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	  \$0  100%	  3 pints  \$0	  \$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan D

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpa- tient medical and surgical ser- vices and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.  First \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$155 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>  First 3 Pints  Next \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All Costs  \$0  20%	\$0  \$155 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY            SERVICES</b>  TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>HOME HEALTH CARE</b> <b>- MEDICARE APPROVED</b> <b>SERVICES</b>  Medically necessary skilled care services and medical supplies  Durable Medical Equipment:  First \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$155 (Part B Deductible)  \$0

# Plan D

## PARTS A & B CONTINUED

### OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.  First \$250 each calendar year  Remainder of charges	    \$0   \$0	    \$0   80% to a lifetime maximum benefit of \$50,000	    \$250   20% and amounts over the \$50,000 lifetime maximum

# Plan F

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days  Beyond the Additional 365 Days	          All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	          \$1,100 (Part A Deductible)  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	          \$0  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	          All approved amounts  All but \$137.50 a day  \$0	          \$0  Up to \$137.50 a day  \$0	          \$0  \$0  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	  \$0  100%	  3 pints  \$0	  \$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan F

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$155 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%   \$0 80%	\$0   \$155 (Part B Deductible) 20%	\$0   \$0 \$0

# Plan F

## OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>FOREIGN TRAVEL- NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside of the U.S.A. First \$250 each calendar year Remainder of Charges	   \$0 \$0	   \$0 80% to a lifetime maximum benefit of \$50,000	   \$250 20% and amounts over the \$50,000 lifetime maximum

# Plan G

## Medicare (Part A) - Hospital Services - Per Benefit Period

\*A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days (Lifetime)  Beyond the Additional 365 Days	          All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	          \$1,100 (Part A Deductible)  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	          \$0  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	          All approved amounts  All but \$137.50 a day  \$0	          \$0  Up to \$137.50 a day  \$0	          \$0  \$0  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	  \$0  100%	  3 pints  \$0	  \$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan G

## Medicare (Part B) - Medical Services - Per Calendar Year.

\*Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpa- tient medical and surgical ser- vices and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	0%
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$155 (Part B Deductible) \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOME HEALTH CARE</b> <b>- MEDICARE APPROVED</b> <b>SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B Deductible) \$0



# Plan G

## OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>FOREIGN TRAVEL- NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside of the U.S.A.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# Plan N

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st through 90th day 91st day and after: While using 60 Lifetime Reserve Days Once Lifetime Reserve Days are used: Additional 365 Days Beyond the Additional 365 Days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A Deductible) \$275 a day \$550 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan N

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.  First \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copay- ment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$155 (Part B Deductible)  Up to \$20 per office visit and up to \$50 per emer- gency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>  First 3 Pints  Next \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All Costs  \$0  20%	\$0  \$155 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES</b>  TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

# Plan N

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment:			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

## OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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**READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Policyholder  
Services & Claims  
(800) 934-8203

**MARQUETTE**  
**NATIONAL**  
LIFE INSURANCE COMPANY

P.O. Box 130  
Pensacola, FL 32591-0130

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SERFF Tracking Number: UNAM-126734366 State: Arkansas

Filing Company: Marquette National Life Insurance Company State Tracking Number: 46293

Company Tracking Number: MMSA-10-PLAN N AR

TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
Standard Plans 2010

Product Name: 2010 Medicare Supplement

Project Name/Number: Plan N/

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 08/26/2010	Rates	MMSI-10-PLAN N AR	New		Rates Plan N.pdf
Approved 08/26/2010	Rates	MMSI-S-10-PLAN N AR	New		Rates Select Plan N.pdf

# Marquette National Life Insurance Company

## Actuarial Justification of Premium Rates

### Individual Medicare Plan N -Standard

Arkansas

#### Exhibit A1 - Annual Premium Rates for Area Factor = 1.00

<u>Age</u>	<u>Preferred</u>	<u>Standard</u>
All	1,581	1,818

**Marquette National Life Insurance Company**

**Actuarial Justification of Premium Rates**

**Individual Medicare Plan N -Select**

Arkansas

**Exhibit A1 - Annual Premium Rates for Area Factor = 1.00**

<u>Age</u>	<u>Preferred</u>	<u>Standard</u>
All	1,440	1,656



SERFF Tracking Number:	UNAM-126734366	State:	Arkansas
Filing Company:	Marquette National Life Insurance Company	State Tracking Number:	46293
Company Tracking Number:	MMSA-10-PLAN N AR		
TOI:	MS08I Individual Medicare Supplement - Standard Plans 2010	Sub-TOI:	MS08I.001 Plan A 2010
Product Name:	2010 Medicare Supplement		
Project Name/Number:	Plan N/		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Accepted for Informational Purposes	08/26/2010
<b>Comments:</b>		
<b>Attachment:</b>		
Readability Certification.pdf		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Application	Approved	08/26/2010
<b>Comments:</b>		
The application was previously approved on December 9, 2005.		
<b>Attachment:</b>		
MN-MSUP-APP (1-06) AR.pdf		

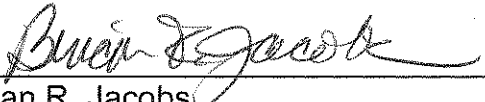
	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage	Approved	08/26/2010
<b>Comments:</b>		
<b>Attachment:</b>		
Outline of Coverage.pdf		

## READABILITY CERTIFICATION

Filing for: Marquette National Life Insurance Company  
1001 Heathrow Park Lane  
Lake Mary, Florida 32746

FORM NO.	DESCRIPTION	TEST SCORE
MMSI-10-PLAN N AR	Medicare Supplement Policy Plan N	42.4
MMSI-S-10-PLAN N AR	Medicare Select Policy Plan N	40.7

I certify that the Flesch Reading Ease Scores for the above form is true and correct.

  
Brian R. Jacobs  
Vice President  
Market Conduct Compliance

July 21, 2010  
Date

# MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: McKinney, Texas • Administrative Office: P.O. Box 13547, Pensacola, Florida 32591-3547

## APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

### PART I: APPLICANT INFORMATION

Proposed Insured	Spouse
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone #: ( ) Best time to call _____ AM or PM	Phone #: ( ) Best time to call _____ AM or PM
Social Security #: - - DOB: / /	Social Security #: - - DOB: / /
Medicare #:	Medicare #:
Height: Weight: Sex: Age:	Height: Weight: Sex: Age:
Name & Address of family doctor:	Name & Address of family doctor:
Beneficiary:	Beneficiary:
Relationship:	Relationship:
Proposed Effective Date:	Proposed Effective Date:

### PART II: COVERAGE APPLIED FOR

MEDICARE SUPPLEMENT PLAN		MEDICARE SELECT PLAN	
<b>PROPOSED INSURED</b>	<b>SPOUSE</b>	<b>PROPOSED INSURED</b>	<b>SPOUSE</b>
Plan _____ Premium Class _____	Plan _____ Premium Class _____	Plan _____ Premium Class _____	Plan _____ Premium Class _____

### PART III: MEDICAL & GENERAL (A telephone interview with the applicant(s) may be conducted to verify application)

Basic Questions (Answer for both Insureds)		
If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.		
<b>To the best of your knowledge:</b>	<b>Proposed Insured</b>	<b>Spouse</b>
1. Did you turn age 65 in the last 6 months? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Did you enroll in Medicare Part B in the last 6 months? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If yes, what is the effective date? Insured _____ Spouse _____		
2. Are you covered for medical assistance through the state Medicaid program? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)		
If Yes,		
a. Will Medicaid pay your premiums for this Medicare supplement policy? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Part III questions continue on next page		

**PART III: MEDICAL & GENERAL** (A telephone interview with the applicant(s) may be conducted to verify application)**Basic Questions (Answer for both Insureds)** *Continued from previous page***To the best of your knowledge:**

3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below.

If you are still covered under this plan, leave "END" blank.

Insured: START \_\_\_/\_\_\_/\_\_\_ END \_\_\_/\_\_\_/\_\_\_ Spouse: START \_\_\_/\_\_\_/\_\_\_ END \_\_\_/\_\_\_/\_\_\_

- b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? .....
- c. Was this your first time in this type of Medicare plan? .....
- d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? .....
4. a. Do you have another Medicare supplement policy in force? .....
- b. If so, with what company?

Insured: \_\_\_\_\_

Spouse: \_\_\_\_\_

- c. What plan do you have?

Insured: \_\_\_\_\_

Spouse: \_\_\_\_\_

- d. If so, do you intend to replace your current Medicare supplement policy with this policy? ...
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) .....
- a. If so, with what company?

Insured: \_\_\_\_\_

Spouse: \_\_\_\_\_

- b. What kind of policy?

Insured: \_\_\_\_\_

Spouse: \_\_\_\_\_

- c. What are your dates of coverage under the other policy?

Insured: START \_\_\_/\_\_\_/\_\_\_ END \_\_\_/\_\_\_/\_\_\_

Spouse: START \_\_\_/\_\_\_/\_\_\_ END \_\_\_/\_\_\_/\_\_\_

(If you are still covered under the other policy, leave "END" blank.)

**Proposed  
Insured****Spouse**☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No**Health Questions (Answer for both Insureds)**

Do not answer questions 1-9 if you are applying for this coverage within 6 months of obtaining Medicare Part B, or under guaranteed issue status.

**IF THE ANSWER TO ANY OF QUESTIONS 2-8 IS "YES" FOR EITHER APPLICANT, THEN THAT APPLICANT IS NOT ELIGIBLE FOR COVERAGE AND HIS OR HER APPLICATION SHOULD NOT BE SUBMITTED.**

1. Have you used tobacco within the last 12 months? .....
2. Is any person to be insured currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, received home health care in the past 90 days; or has any such care been medically advised? .....
3. Has any person to be insured been diagnosed, treated or been advised by a physician that they have Alzheimer's Disease, Senile Dementia, Organic Brain Disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Muscular Dystrophy or paralysis?
4. Has any person to be insured tested positive for exposure to the HIV infection or been diagnosed and advised by a physician that they have Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....
5. Has any person to be insured been diagnosed with Diabetes requiring the use of Insulin, Kidney Disease requiring dialysis, received or is awaiting an organ transplant? .....

**Proposed  
Insured****Spouse**☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No☐Yes ☐No*Health Questions continue on next page*

	Proposed Insured	Spouse
6. Within the past two years has any person to be insured had, been treated for or been advised by a physician to have treatment for:		
a. Congestive Heart Failure, Heart Attack, Angina (chest pain), Coronary Artery Disease, Cardiomyopathy, Stroke (CVA), Transient Ischemic Attack (TIA), Heart Rhythm Disorders requiring pacemaker or defibrillator? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Cancer (except skin cancer), Melanoma, Hodgkin's Disease or Leukemia? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Emphysema, Chronic Obstructive Pulmonary or Lung Disease, or use of Oxygen? . . . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any person to be insured been hospitalized two or more times within the past 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any person to be insured been advised to have surgery, medical tests or treatment that has not been performed or have they had medical test(s) for which they have not received the results? . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any person to be insured taken any prescription medications within the past 12 months? . .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes provide details (attach a separate sheet if necessary):		

[illegible]

## PART IV - CREDITABLE COVERAGE DETERMINATION

Within the last 63 days, have you been or were you covered under creditable coverage\*?

Proposed Insured: ☐ Yes ☐ No      Spouse: ☐ Yes ☐ No

If “yes”, what type of coverage? Insured: \_\_\_\_\_ Spouse: \_\_\_\_\_

If “yes”, with what company? Insured: \_\_\_\_\_ Policy No.: \_\_\_\_\_  
Spouse: \_\_\_\_\_ Policy No.: \_\_\_\_\_

\*“Creditable Coverage” means (a) a group health plan; (b) health insurance coverage; (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare); (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of Title 10 (CHAMPUS); (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of Title 5 (Federal Employees Health Benefits Program); (i) a public health plan (as defined in federal regulation); or (j) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)). Creditable Coverage does not include hospital indemnity, specified disease or illness, accident or disability income plans.

## PART V - INSURED CERTIFICATION

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or if that is no longer available, substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

To the best of my knowledge and belief, all of the answers to the above questions are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company and the full first premium has been paid; (b) this policy has a pre-existing condition limitation. A pre-existing condition means a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage. No coverage will be provided for a pre-existing condition until 6 months after the policy has been issued. All other conditions are covered from the date the policy is issued; and (c) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. **The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that he realized that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.**

**Authorization:** I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, The Medical Information Bureau, Pharmaceutical Database, other organization, institution or person, that has any records or knowledge of me, or my health, to give Marquette National Life Insurance Company or its reinsurer(s) any such information. A photographic copy of this authorization shall be as valid as the original. **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I acknowledge receiving: (a) "A Guide to Health Insurance for People With Medicare"; (b) Outline of Coverage; (c) Investigative Consumer Report Notice; and (d) Medical Information Bureau (MIB) Disclosure Notice.

Signed at \_\_\_\_\_ Date \_\_\_\_\_  
(City) (State) (Month/ Day) (Year)

X \_\_\_\_\_  
(Applicant's Signature)

X \_\_\_\_\_  
(Spouse's Signature if applying for coverage)

## PART VI - AGENT CERTIFICATION

The undersigned Agent certifies that the Applicant(s) has read, or had read to him/her, the completed application and that the Applicant(s) realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. AGENT COMPLETES (attach separate sheet, if necessary.)

**TO AGENT:** List all Health Insurance Policies sold to the applicant(s) which are still in force.

COMPANY \_\_\_\_\_ TYPE \_\_\_\_\_

List all Health Insurance Policies sold to the applicant(s) within the past 5 years which are no longer in force.

COMPANY \_\_\_\_\_ TYPE \_\_\_\_\_

**I certify:** (1) I have accurately recorded the information supplied by the Applicant(s); and (2) I have given an outline of coverage for the policy applied for and a "A Guide to Health Insurance for People With Medicare" to the Applicant(s).

X \_\_\_\_\_ 

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 % \_\_\_\_\_  
Licensed Agent's Signature      Agent's Code      Off. Code      Print Agent's Name      Agent's State Identification

X \_\_\_\_\_ 

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 % \_\_\_\_\_  
Secondary Agent's Signature      Secondary Agent Code      Off. Code      Secondary Agent Print Name      Secondary Agent Identification

Send Policy to: ☐ Agent    ☐ Insured

## SUPPLEMENT TO APPLICATION MN-MSUP-APP (1/06) AR

### PLEASE PRINT

Proposed Insured \_\_\_\_\_ Spouse \_\_\_\_\_  
(if applying for coverage)      (if applying for coverage)

Beneficiary \_\_\_\_\_ Beneficiary \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Automatic Premium Loan    ☐ Yes    ☐ No      Automatic Premium Loan    ☐ Yes    ☐ No

If you are in open enrollment or eligible for guaranteed issue for a Medicare Supplement/Select policy and are applying for life insurance, you must answer questions 1 through 9 on this application.

Issue ages 65-79      Primary Insured -      Face Amount    ☐ \$2,500    ☐ \$5,000    ☐ \$7,500    ☐ \$10,000    ☐ \_\_\_\_\_ \*  
   Spouse -      Face Amount    ☐ \$2,500    ☐ \$5,000    ☐ \$7,500    ☐ \$10,000    ☐ \_\_\_\_\_ \*

\* Amount must be between \$2,500 and \$10,000.

Is any insurance applied for intended to replace any life insurance or annuity currently in force? .....

PROPOSED  
INSURED      SPOUSE  
☐ Yes    ☐ No      ☐ Yes    ☐ No

If "Yes" complete and attach the appropriate replacement forms (if applicable).

Proposed Insured: \_\_\_\_\_  
   Company      Policy Number

Spouse: \_\_\_\_\_  
   Company      Policy Number

I hereby apply for life insurance as shown above based on my attached application. The answers are, to the best of my knowledge and belief, true. I agree any policy shall not be effective until it has actually been issued.

Date: \_\_\_\_\_ Signature of Proposed Insured: X \_\_\_\_\_  
(if applying for coverage)

Date: \_\_\_\_\_ Signature of Spouse: X \_\_\_\_\_  
(if applying for coverage)

### PREMIUM MODE:

#### DIRECT

- ☐ Annual  
☐ Semi Annual  
☐ Quarterly  
☐ Monthly PAC

#### CREDIT CARD

- ☐ Annual  
☐ Semi Annual  
☐ Quarterly  
☐ Monthly

### PREMIUM

Insured    Spouse

Medicare Supplement    \$ \_\_\_\_\_    \$ \_\_\_\_\_

Life Insurance    \$ \_\_\_\_\_    \$ \_\_\_\_\_

**TOTAL AMOUNT COLLECTED**    \$ \_\_\_\_\_    \$ \_\_\_\_\_

# Marquette National Life Insurance Company

## Senior Health Service Center

P.O. Box 130 • Pensacola, Florida 32591-0130

### 2010 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE 1 OF 2

#### BENEFIT PLANS A, B, C, D, F, G AND N

Medicare supplement insurance can be sold in only ten standard plans plus a high deductible plan. This chart shows the benefits included in each plan. Every company must make available Plan “A”. Some plans may not be available in your state. Plans E, H, I and J are no longer available for sale.

**BASIC BENEFITS** included in all Plans: **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end; **Medical Expenses** — Part B coinsurance (generally 20% of Medicare-approved expenses); or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments; **Blood** — First three pints of blood each year; and **Hospice** — Part A coinsurance.

B E N E F I T S	PLANS						
	★ A	B	C	★ D*	★ F*	F**	★ G*
	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance	Basic INCLUDING 100% Part B coinsurance
			Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
			Part B Deductible		Part B Deductible	Part B Deductible	
					Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
			Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

★Marks the plans being offered by Marquette National Life Insurance Company.

\*Plans D, F, G and N are also offered as Medicare Supplement Select plans. If you choose a Medicare Select plan, when medical care is provided in a network hospital, the initial Part A Deductible is waived. If medical care is provided in a non-network provider hospital, you are responsible for payment of the initial Part A Deductible.

\*\*Plan “F” also has an option called a high deductible plan pays the same or offer the same benefits as Plan “F” after one has paid a calendar year \$2,000 deductible. Benefits from high deductible Plan “F” will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.



# Marquette National Life Insurance Company

Senior Health Service Center

P.O. Box 130 • Pensacola, Florida 32591-0130

## 2010 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE 2

PLANS				
B E N E F I T S	K**	L**	M	★ N*
	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic INCLUDING 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
			Foreign Travel Emergency	Foreign Travel Emergency
	Out-of-pocket limit \$[4,620] paid at 100% after limit reached***	Out-of-pocket limit \$[2,310] paid at 100% after limit reached***		

\*\* The out-of-pocket annual limit does NOT include charges from your provider that exceed medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

\*\*\*The out-of-pocket annual limit will increase each year for inflation.

# Marquette National Life Insurance Company

Use these rates:	If you live in these zip codes:
Area 1	716, 717, 719, 723-729
Area 2	718, 720, 721
Area 3	722

## MEDICARE SUPPLEMENT

## ARKANSAS

### MALE & FEMALE

AREA 1											
Premium Mode	Age	PLAN A		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,390	\$ 1,598	\$ 1,713	\$ 1,970	\$ 1,949	\$ 2,242	\$ 1,812	\$ 2,084	\$ 1,423	\$ 1,636
Semi-Annual	65 and above	723	831	891	1,024	1,014	1,166	942	1,083	740	851
Quarterly	65 and above	368	424	454	522	517	594	480	552	377	434
Monthly CC	65 and above	118	136	146	167	166	191	154	177	121	139
Monthly PAC	65 and above	116	133	143	164	162	187	151	174	119	136

AREA 2											
Premium Mode	Age	PLAN A		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,467	\$ 1,687	\$ 1,808	\$ 2,080	\$ 2,058	\$ 2,366	\$ 1,912	\$ 2,199	\$ 1,502	\$ 1,727
Semi-Annual	65 and above	763	877	940	1,081	1,070	1,231	994	1,144	781	898
Quarterly	65 and above	389	447	479	551	545	627	507	583	398	458
Monthly CC	65 and above	125	143	154	177	175	201	163	187	128	147
Monthly PAC	65 and above	122	141	151	173	171	197	159	183	125	144

AREA 3											
Premium Mode	Age	PLAN A		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,544	\$ 1,776	\$ 1,903	\$ 2,189	\$ 2,166	\$ 2,491	\$ 2,013	\$ 2,315	\$ 1,581	\$ 1,818
Semi-Annual	65 and above	803	924	990	1,138	1,126	1,295	1,047	1,204	822	945
Quarterly	65 and above	409	471	504	580	574	660	533	613	419	482
Monthly CC	65 and above	131	151	162	186	184	212	171	197	134	155
Monthly PAC	65 and above	129	148	159	182	180	208	168	193	132	151

Rate is determined by Underwriting Class and Zip Code. Open Enrollees and Guaranteed Issues use Preferred rate.

# Marquette National Life Insurance Company

Use these rates:	If you live in these zip codes:
Area 1	716, 717, 719, 723-729
Area 2	718, 720, 721
Area 3	722

**MEDICARE  
SELECT**

**ARKANSAS**

## MALE & FEMALE

### AREA 1

Premium Mode	Age	PLAN A (non-SELECT)		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,390	\$ 1,598	\$ 1,540	\$ 1,771	\$ 1,769	\$ 2,035	\$ 1,632	\$ 1,877	\$ 1,296	\$ 1,490
Semi-Annual	65 and above	723	831	801	921	920	1,058	848	976	674	775
Quarterly	65 and above	368	424	408	469	469	539	432	497	343	395
Monthly CC	65 and above	118	136	131	151	150	173	139	160	110	127
Monthly PAC	65 and above	116	133	128	148	147	170	136	156	108	124

### AREA 2

Premium Mode	Age	PLAN A (non-SELECT)		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,467	\$ 1,687	\$ 1,625	\$ 1,870	\$ 1,868	\$ 2,148	\$ 1,722	\$ 1,981	\$ 1,368	\$ 1,573
Semi-Annual	65 and above	763	877	845	972	971	1,117	896	1,030	711	818
Quarterly	65 and above	389	447	431	495	495	569	456	525	363	417
Monthly CC	65 and above	125	143	138	159	159	183	146	168	116	134
Monthly PAC	65 and above	122	141	135	156	156	179	144	165	114	131

### AREA 3

Premium Mode	Age	PLAN A (non-SELECT)		PLAN D		PLAN F		PLAN G		PLAN N	
		Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard	Preferred	Standard
Annual	65 and above	\$ 1,544	\$ 1,776	\$ 1,711	\$ 1,968	\$ 1,966	\$ 2,261	\$ 1,813	\$ 2,085	\$ 1,440	\$ 1,656
Semi-Annual	65 and above	803	924	890	1,023	1,022	1,176	943	1,084	749	861
Quarterly	65 and above	409	471	453	522	521	599	480	553	382	439
Monthly CC	65 and above	131	151	145	167	167	192	154	177	122	141
Monthly PAC	65 and above	129	148	143	164	164	188	151	174	120	138

Rate is determined by Underwriting Class and Zip Code. Open Enrollees and Guaranteed Issues use Preferred rate.

### **PREMIUM INFORMATION**

We, Marquette National Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. The premium you pay at each premium due date will be based on the state in which your policy was purchased. The premium amount does not increase each year because of an increase in attained age.

The Premium for this Policy is: Plan \_\_\_\_\_

Annually \$ \_\_\_\_\_; Semi-Annually \$ \_\_\_\_\_;

Quarterly \$ \_\_\_\_\_; Monthly PAC \$ \_\_\_\_\_; Credit Card \$ \_\_\_\_\_

### **DISCLOSURES**

Use this Outline to compare benefits and premiums among policies. This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.

### **READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to our Administrative Office, P.O. Box 13547, Pensacola, Florida 32591-3547. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

### **POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

### **NOTICE**

This policy may not fully cover all of your medical costs. Neither Marquette National nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "*Medicare and You*" for more details.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

## **GRIEVANCE PROCEDURE\***

We have a customer service program which can provide information to you, handle your complaints and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program, or that you desire to have settled by means of a written grievance.

If while staying at a Network Hospital, you have a complaint regarding hospital services being provided, you may contact the Claims Department by phone (800-934-8203) to express the complaint. The Claims Department will relay the complaint to the Network Hospital's Administration on an immediate basis for prompt resolution.

The following procedures are aimed at achieving mutual agreement for the settlement of a dispute.

1. All grievances must be presented to us in written form. Any written grievance between you and us, or between you and a hospital, must be dealt with through this grievance procedure.
2. Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.
3. A grievance must be filed by submitting the complete details in writing to Marquette National Life Insurance Company, c/o Grievance Appeal Manager, 411 N. Baylen Street, Pensacola, FL 32502.
4. Each grievance is processed within a maximum of 60 days after it is received by us. Each level of the grievance process is handled by a person with problem-solving authority. A physician, other than your primary care physician, must be involved in reviewing any medically related grievances.
5. If a grievance is found to be valid, corrective action will be taken promptly.
6. All concerned parties are to be notified about the result of a grievance.
7. You have the right to appeal to the Department of Insurance after first completing our grievance process.
8. If, after completing all the steps in the grievance procedure the problem is not satisfactorily resolved, you may request arbitration. Arbitration must be conducted in accordance with the provisions of the applicable state statute.
9. Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.
10. The time for filing a grievance is limited to a period of not more than one year from the date of occurrence.

\*Grievance Procedure only applies to Medicare Select Plans.

# Plan A

## Medicare (Part A) - Hospital Services - Per Benefit Period

\*A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days  Beyond the Additional 365 Days	All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	\$0  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	\$1,100 (Part A Deductible)  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	All approved amounts  All but \$137.50 a day  \$0	\$0  \$0  \$0	\$0  Up to \$137.50 a day  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	\$0  100%	3 pints  \$0	\$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan A

## Medicare (Part B) - Medical Services - Per Calendar Year

\*Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.  First \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	  \$0  Generally 80%	  \$0  Generally 20%	  \$155 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 Pints  Next \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	 \$0  \$0  80%	 All Costs  \$0  20%	 \$0  \$155 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies  Durable Medical Equipment:  First \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	 100%   \$0  80%	 \$0  \$0  20%	   \$0  \$155 (Part B Deductible)  \$0

# Plan B

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*\* If you do not utilize a network provider for Medicare Select plans, you are responsible for the Part A Deductible.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st through 90th day 91st day and after: While using 60 Lifetime Reserve Days Once Lifetime Reserve Days are used: Additional 365 Days Beyond the Additional 365 Days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A Deductible)*** \$275 a day \$550 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.



# Plan B

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$155 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B Deductible) \$0

# Plan C

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st through 90th day 91st day and after: While using 60 Lifetime Reserve Days Once Lifetime Reserve Days are used: Additional 365 Days Beyond the Additional 365 Days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A Deductible) \$275 a day \$550 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan C

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$155 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%   \$0 80%	\$0   \$155 (Part B Deductible) 20%	\$0   \$0 \$0

(continued)

# Plan C

## OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>FOREIGN TRAVEL- NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside of the U.S.A. First \$250 each calendar year Remainder of Charges	  \$0 \$0	  \$0 80% to a lifetime maximum benefit of \$50,000	  \$250 20% and amounts over the \$50,000 lifetime maximum

# Plan D

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days  Beyond the Additional 365 Days	          All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	          \$1,100 (Part A Deductible)  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	          \$0  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	          All approved amounts  All but \$137.50 a day  \$0	          \$0  Up to \$137.50 a day  \$0	          \$0  \$0  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	  \$0  100%	  3 pints  \$0	  \$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan D

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpa- tient medical and surgical ser- vices and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.  First \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$155 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>  First 3 Pints  Next \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All Costs  \$0  20%	\$0  \$155 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES</b>  TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>HOME HEALTH CARE</b> <b>- MEDICARE APPROVED</b> <b>SERVICES</b>  Medically necessary skilled care services and medical supplies  Durable Medical Equipment:  First \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$155 (Part B Deductible)  \$0

# Plan D

## PARTS A & B CONTINUED

### OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.  First \$250 each calendar year  Remainder of charges	     \$0   \$0	     \$0   80% to a lifetime maximum benefit of \$50,000	     \$250   20% and amounts over the \$50,000 lifetime maximum

# Plan F

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days  Beyond the Additional 365 Days	          All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	          \$1,100 (Part A Deductible)  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	          \$0  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	          All approved amounts  All but \$137.50 a day  \$0	          \$0  Up to \$137.50 a day  \$0	          \$0  \$0  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	  \$0  100%	  3 pints  \$0	  \$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.



# Plan F

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$155 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%   \$0 80%	\$0   \$155 (Part B Deductible) 20%	\$0   \$0 \$0

# Plan F

## OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>FOREIGN TRAVEL-</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside of the U.S.A. First \$250 each calendar year Remainder of Charges	   \$0 \$0	   \$0 80% to a lifetime maximum benefit of \$50,000	   \$250 20% and amounts over the \$50,000 lifetime maximum

# Plan G

## Medicare (Part A) - Hospital Services - Per Benefit Period

\*A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies.  First 60 days  61st through 90th day  91st day and after: While using 60 Lifetime Reserve Days  Once Lifetime Reserve Days are used: Additional 365 Days (Lifetime)  Beyond the Additional 365 Days	          All but \$1,100  All but \$275 a day  All but \$550 a day  \$0  \$0	          \$1,100 (Part A Deductible)  \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	          \$0  \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.  First 20 days  21st through 100th day  101st day and after	          All approved amounts  All but \$137.50 a day  \$0	          \$0  Up to \$137.50 a day  \$0	          \$0  \$0  All Costs
<b>BLOOD</b> First 3 pints  Additional Amounts	  \$0  100%	  3 pints  \$0	  \$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan G

## Medicare (Part B) - Medical Services - Per Calendar Year.

\*Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpa- tient medical and surgical ser- vices and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	0%
<b>BLOOD</b> First 3 Pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$155 (Part B Deductible) \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOME HEALTH CARE</b> <b>- MEDICARE APPROVED</b> <b>SERVICES</b> Medically necessary skilled care services and medical supplies Durable Medical Equipment: First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B Deductible) \$0

# Plan G

## OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>FOREIGN TRAVEL- NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside of the U.S.A.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# Plan N

## Medicare (Part A) - Hospital Services - Per Benefit Period

\* A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st through 90th day 91st day and after: While using 60 Lifetime Reserve Days Once Lifetime Reserve Days are used: Additional 365 Days Beyond the Additional 365 Days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A Deductible) \$275 a day \$550 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctors certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan N

## Medicare (Part B) - Medical Services - Per Calendar Year

\* Once you have been billed \$155 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.  First \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copay- ment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$155 (Part B Deductible)  Up to \$20 per office visit and up to \$50 per emer- gency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>  First 3 Pints  Next \$155 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All Costs  \$0  20%	\$0  \$155 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES</b>  TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

# Plan N

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment:			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

## OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



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**READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Policyholder  
Services & Claims  
(800) 934-8203

**MARQUETTE**  
**NATIONAL**  
LIFE INSURANCE COMPANY

P.O. Box 130  
Pensacola, FL 32591-0130

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<i>SERFF Tracking Number:</i>	<i>UNAM-126734366</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Marquette National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>46293</i>
<i>Company Tracking Number:</i>	<i>MMSA-10-PLAN N AR</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement -</i>	<i>Sub-TOI:</i>	<i>MS08I.001 Plan A 2010</i>
	<i>Standard Plans 2010</i>		
<i>Product Name:</i>	<i>2010 Medicare Supplement</i>		
<i>Project Name/Number:</i>	<i>Plan N/</i>		

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/22/2010	Form	Medicare Supplement Plan N	08/26/2010	Medicare Supplement Plan N.pdf (Superceded)

# MARQUETTE NATIONAL LIFE INSURANCE COMPANY

Home Office: Houston, Texas  
Administrative Office: P. O. Box 13547, Pensacola, Florida 32591-3547  
Phone: (800) 934-8203  
A Stock Company

## MEDICARE SUPPLEMENT POLICY – PLAN N

### IMPORTANT NOTICE

PLEASE READ THE COPY OF YOUR APPLICATION ATTACHED TO THIS POLICY. OMISSIONS OR MATERIAL MISSTATEMENTS IN THE APPLICATION COULD CAUSE AN OTHERWISE VALID CLAIM TO BE DENIED AND YOUR POLICY RESCINDED. REVIEW THE APPLICATION AND WRITE US AT THE ADDRESS SHOWN ABOVE, WITHIN 30 DAYS, IF ANY INFORMATION IS NOT CORRECT OR IF ANY PAST MEDICAL HISTORY HAS BEEN LEFT OUT. NO CHANGE IN THIS POLICY SHALL BE VALID UNTIL APPROVED BY AN EXECUTIVE OFFICER OF THE INSURER AND UNLESS SUCH APPROVAL BE ENDORSED HEREON OR ATTACHED HERETO. NO AGENT HAS THE AUTHORITY TO CHANGE THIS POLICY OR TO WAIVE ANY OF ITS PROVISIONS.

**THIS IS A LEGAL CONTRACT. PLEASE READ IT CAREFULLY.**

**NOTICE TO THE BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

### PART 1

#### RENEWAL PROVISIONS

**This Policy is Guaranteed Renewable For Life. We Reserve The Right to Change Premium Rates.**

You may renew this policy for life by paying the premiums when due. This means that we agree to keep your coverage in force as long as you continue to pay the premiums on a timely basis (see Grace Period provision). While this policy is in force, we agree never to rider, reduce benefits, or change this policy in any way because of a change in your health.

### PREMIUMS

Premiums do not increase each year because of an increase in attained age. On each premium due date, the premium may change if a new rate is applicable to the policy. The increase applies to all covered persons in the same class. You will be notified in writing at least 31 days before any change in the rates.

### PREMIUM RATES SUBJECT TO CHANGE


#### Notice of Your Right to Examine Policy for 30 Days

If, for any reason, you are not satisfied with this policy, you can return it to us for a prompt and full refund. You can mail it to us at our Administrative Office, P.O. Box 13547, Pensacola, Florida 32591-3547, or to the agent through whom it was purchased. It must however, be mailed within 30 days from the date you received it.

This is a non-participating policy. It will not share in any distribution of our profits or surplus earnings. We will not pay any dividends on this policy.

Marquette National Life Insurance Company has caused this policy to be signed by its President and Secretary.

  
Secretary

  
President

### MEDICARE SUPPLEMENT POLICY – PLAN D

#### NON-PARTICIPATING

For Service or Information Call (800) 934-8203

**THIS POLICY CONTAINS A PRE-EXISTING CONDITION LIMITATION**

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**PART 2**

**POLICY SCHEDULE**

**MEDICARE SUPPLEMENT PLAN N**

POLICY: [018042601]

EFFECTIVE DATE: [June 1, 2010]

INSURED'S NAME: [John A. Doe]

AGE: [65]

INITIAL PREMIUM: \$[XXX.XX]

PREMIUM MODE: [Annual]

MODE PREMIUM:	ANNUALLY:	\$[XXX.XX]	SEMI-ANNUALLY:	\$[XXX.XX]
	QUARTERLY:	\$[XXX.XX]	MONTHLY PAC:	\$[XX.XX]
	CREDIT CARD:	\$[XX.XX]		

FIRST RENEWAL DATE: [June 1, 2011]

THE PREMIUM MAY CHANGE ON A CLASS BASIS, AS DESCRIBED ON PAGE 1 OF THIS POLICY.

### **PART 3 INSURING AGREEMENT**

#### **Who Is Covered**

We hereby insure you for losses from injury and sickness. The payment of benefits is subject to all of the provisions, definitions and limitations contained in this policy. This contract is made with you as the signer of the application for this policy. Every transaction relating to this policy is strictly between you and us.

#### **Consideration**

This policy is issued in consideration of your statements and answers made in the application and the advance payment of the first premium. A copy of the application is attached to, and made a part of this policy. Please read the copy of your application attached to this policy. Omissions or material misstatements in the application could cause an otherwise valid claim to be denied. Review the application and write us within 30 days if any information is not correct or if any past medical history has been left out.

#### **When Coverage Is Effective**

This policy shall take effect at 12:00 a.m., midnight, Standard Time, at the place where you live. The initial term ends at the same hour of the last day of the grace period, on which the initial term expires. The effective date of this policy, the initial premium and first renewal date are all shown in the Policy Schedule.

### **PART 4 PLAN OF BENEFITS - PLAN D**

**Co-payments apply to physician office visits, including visits to medical specialists, and to emergency room visits. The emergency room co-payment will be waived if you are admitted to the hospital, and the visit is subsequently covered as a Medicare Part A expense.**

#### **What We Will Pay**

##### **CORE BENEFITS**

When you are confined in a Hospital as a Resident Patient and Medicare pays for the confinement, we will pay Medicare Eligible Expenses as follows during each benefit period. Such confinement must be due to injury or sickness.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61<sup>st</sup> day through the 90<sup>th</sup> day in any Medicare benefit period.
2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

## **ADDITIONAL BENEFITS**

1. Medicare Part A Deductible: Coverage for the Medicare Part A inpatient hospital deductible amount per benefit period.
2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.
3. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

## **PART 5 ELIGIBILITY**

### **Who Can Be Insured**

Only you are eligible to be covered. In addition, you must be: (1) age 65; and (2) covered by Medicare Parts A and B.

## **PART 6 TERMINATION OF COVERAGE**

### **Lifetime Coverage If Premiums Are Paid**

The insurance coverage shall continue for life, provided all premiums are paid.

If any premium payment is not received by us or paid to an agent authorized by us, on or before any premium due date, or within the grace period as provided, this policy shall terminate without further notice. However, such termination is without prejudice to any claim for loss incurred prior to that time.

## **PART 7 PRE-EXISTING CONDITION LIMITATIONS**

### **Pre-Existing Conditions Are Not Covered For 6 Months**

Pre-existing Conditions are covered after this policy has been in force for 6 months. See definition of Pre-existing Condition in Part 10.

If, as of the date of application, you had a Continuous Period of Creditable Coverage or had prior coverage under a Medicare Supplement policy for at least 6 months, we will not exclude benefits based on a pre-existing condition. If, as of the date of application, you had a Continuous Period of Creditable Coverage or had prior coverage under a Medicare Supplement policy for less than 6 months, we will reduce the period of the pre-existing condition limitation by the time covered under such prior coverage.

We will waive any pre-existing condition limitation if you applied for and were issued this policy under a qualified guaranteed issue status.

## **PART 8 CHANGES IN MEDICARE**

### **Automatic Benefit Adjustment**

If changes are made in Medicare deductibles, coinsurance payments or other Medicare benefits, coverage provided by this policy will be automatically adjusted to coincide with these changes. The policy benefits will not duplicate benefits paid by Medicare. Premiums may be modified as necessary to correspond with these changes.

**PART 9**  
**SUSPENSION OF COVERAGE BY POLICYHOLDER**

**Entitlement To Title XIX of the Social Security Act "Medicaid"**  
**Or Coverage Under Group Health Plan Under Section 226(b) of the Social Security Act**

If, within ninety (90) days after the date you become entitled to medical assistance under Title XIX of the Social Security Act (Medicaid), you notify us, the benefits and premium under this policy shall be suspended for the period in which you applied for and were determined to be entitled to Medicaid. The suspension period shall not exceed 24 months.

If you become entitled to benefits under section 226 (b) of the Social Security Act (42 USC section 426) and are covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act), at your request the benefits and premiums under this policy will be suspended for any period provided by federal regulation.

If such suspension occurs and you lose entitlement to Medicaid or coverage under a group health plan, this policy will be automatically reinstituted effective as of the date of termination of entitlement to Medicaid or loss of group coverage, if you provide notice of loss of such entitlement to us within ninety (90) days after the date of such loss and pay the premium attributable to the period.

If the coverage of this policy is reinstituted: (1) there will be no waiting period for treatment of pre-existing conditions; (2) the coverage will be substantially equivalent to the coverage in effect before the date of such suspension; and (3) premiums on terms at least as favorable to you as the premium terms you would have had if your coverage had not been suspended.

**PART 10**  
**DEFINITIONS**

**Some Important Definitions Of Words And Phrases**

- A. "Benefit Period" means a period which begins, after the Effective Date of this policy, with the first day you are entitled to benefits under this policy for confinement in a hospital. It ends with the first period of 60 consecutive days thereafter, during which you are not confined in a hospital or skilled nursing care facility.
- B. "Continuous Period of Creditable Coverage" means the period during which you were covered by Creditable Coverage, if during the period of the coverage you had no breaks in coverage greater than 63 days.
- C. "Creditable Coverage" means coverage under any of the following: a) A group health plan; b) Health insurance coverage; c) Part A or Part B of Title XVIII of the Social Security Act (Medicare); d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; e) Chapter 55 of Title 10 (CHAMPUS), f) A medical care program of the Indian Health Service or of a tribal organization; g) A state health benefits risk pool; h) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health benefit program); i) A public health plan (as defined in Federal regulation); or j) A health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).
- D. "Emergency Care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.
- E. "Home" means any place used by you as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing care facility shall not be considered your place of residence.
- F. "Hospice Care" means treatment in a hospice program as defined by Medicare.
- G. "Hospital" means a hospital that is approved or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.
- H. "Injury or Injuries" for which benefits are provided means accidental bodily injury sustained by you which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this policy is in force.



- I. "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.
- J. "Medicare Eligible Expenses" are those expenses of the kind covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
- K. "Physician" means a duly licensed practitioner of the healing arts who is practicing within the scope of his or her license.
- L. "Pre-Existing Condition" means a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
- M. "Resident Patient" means a person confined in a hospital for treatment of injury or sickness. This shall not include a person receiving any form of rest, nursing, convalescent, or custodial care.
- N. "Respite Care" is treatment that meets Medicare's definition of respite care.
- O. "Sickness" means illness or disease incurred by you which was diagnosed or treated after the effective date of this policy and while this policy is in force.
- P. "Skilled Nursing Care Facility" means a facility that is operated pursuant to law; approved for payment of Medicare benefits or be qualified to receive such approval if so requested; be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; provides continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and maintains a daily medical record of each patient. This does not include any home, facility, or part thereof used primarily for rest; a home or facility for the aged or for the care or treatment of drug and alcohol abuse; or a home or facility primarily used for the care and treatment of mental disease or disorders or custodial or educational care.
- Q. "We" or "Us" means our Company named on the first page of the policy.
- R. "You" or "Your" means the person insured by this policy shown as the applicant on the attached application.

## **PART 11 EXCLUSIONS**

### **What We Will Not Pay For**

This policy does not pay for expenses of the kind not covered by Medicare.

## **PART 12 UNIFORM PROVISIONS**

### **Entire Contract; Changes**

This policy with the application and attached papers is the entire contract of insurance between you and our Company. No change in this policy will be valid until approved by an executive officer of the Company. This approval must be noted on or attached to this policy. No agent has the authority to change this policy or waive any of its provisions.

### **Change of Beneficiary**

You can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

### **Time Limit On Certain Defenses**

After two years from the issue date, only fraudulent misstatements made by the applicant in the application may be used to: (1) void the policy; or (2) deny any claim for loss incurred after the 2-year period.

No claim for loss incurred commencing after 6 months from the date of issue of this policy shall be reduced or denied on the grounds that a disease or physical condition effective on the date of loss had existed prior to the effective date of coverage of this policy.

**Grace Period**

This policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period the policy will stay in force.

**Reinstatement**

If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by us (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If we require an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt, unless we have previously written to you giving our disapproval. The reinstated policy will cover only losses that result from an injury or sickness that occurs after the date of reinstatement. In all other respects, your rights, and ours, will remain the same, subject to any provisions noted on, or attached to the reinstated policy.

**Notice of Claim**

Written notice of claim must be given within 20 days after a covered loss starts, or as soon as reasonably possible. The notice can be given to us at our Administrative Office, or to our agent. Notice should include your name and the policy number.

**Claim Forms**

When we receive a notice of claim, we will send you forms for filing proof of loss. If these forms are not given to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

**Time of Payment of Claims**

Benefits for any loss covered by this policy will be paid as soon as we receive proper written proof.

**Proof of Loss**

Written proof of loss must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce nor deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified, unless you were legally incapacitated.

**Payment of Claims**

Benefits will be paid to you. Loss of life benefits are payable in accordance with the beneficiary designation at the time of payment. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at our option, either to your beneficiary or estate. The proceeds payable to the insured or his estate shall include premiums paid for any period beyond the end of the policy month in which death occurred and shall be paid in a lump sum no later than 30 days after we receive proof of the insured's death.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000 to someone related to you or your beneficiary by blood or marriage, whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

**Extension of Benefits**

Termination of a Medicare Supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**Physical Examinations and Autopsy**

We, at our own expense, shall have the right and opportunity to examine the insured when and as often as we may reasonably require while a claim is pending. We shall also have the right to have an autopsy made, at our own expense, unless prohibited by law.

**Legal Action**

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by the policy. No such action may be brought after the expiration of three years from the time written proof of loss is required to be given.

**Misstatement of Age**

If your age has been misstated, benefits will be based on what the premium paid would have purchased at the correct age.

**Unpaid Premium**

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**Conformity With State Statutes**

Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you live on that date, is amended to conform to the minimum requirements of such laws.

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## **MARQUETTE NATIONAL LIFE INSURANCE COMPANY**

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